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ABSTRACT

Cognitive behavioral psychology is a new theoretical orientation and when applied in treatment it is known as cognitive behavior therapy (CBT). Theoretically CBT seeks primarily to change cognitions to alter behaviors and to modify cognitions to affect emotions. In general CBT is considered to be an information processing psychology because it suggests getting people to think differently about themselves and their lives after examining "data" in newly structured ways and then acting differently as a result of that process. This case study examined Bobby R., a 6-year old boy who, during an apparently successful kindergarten year, began suddenly to have great difficulty attending school. Bobby had a definite aversion to school unless at least one of his parents were present, and even then he had much trepidation over entering his kindergarten classroom. This situation had both of his parents extremely upset, and this impacted adversely on Bobby. Yet, Bobby stated strongly that he wanted to attend school. Bobby's contention was accepted easily because when later observed in kindergarten with a parent present, he participated fully and seemed rather happy. Thus, this situation was not only uncomfortable for Bobby personally, it also caused disruption within his family and school. This case was handled through a CBT orientation. After therapy Bobby was able to walk home from school without a parent and participated fully and appropriately with peers and teacher. His self efficacy grew and he began first grade without incidence. (Author/ABL)

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CBT Theory and Its Application: A School Phobic Kindergarten Case

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Abstract

This case is about Bobby R, a 6-year old boy who--during an apparently successful Kindergarten year--began suddenly to have great difficulty attending school. Bobby had a definite aversion to school unless at least one of his parents were present, and even then he had much trepidation over entering his Kindergarten classroom. This situation had both of his parents extremely upset, and this of course impacted adversely on Bobby. Yet, Bobby stated strongly that he wanted to attend school. Bobby's contention was accepted easily because when later observed in Kindergarten with a parent present, he participated fully and seemed rather happy. Thus, this situation was not only uncomfortable for Bobby personally, it also caused disruption within his family and school. This case was handled through a cognitive behavior therapy (CBT) orientation. After CBT theory is explained, the case background, treatment literature, and interventions are presented.

Theoretical Orientation

Cognitive behavioral psychology is a new theoretical orientation; and, when applied in treatment, it is known as cognitive behavior therapy (CBT). CBT, although based primarily on an information processing model (Lehman & Salovey, 1990), rests firmly on the twin pillars of both behaviorism and cognitive psychology (Mahoney, 1974; Meichenbaum, 1974, 1977). Each of the two main posts are explained below.

"Scientific psychology," for approximately 50 or so years and until recently, was dominated by a philosophy of science known as behaviorism (Baars, 1986). It seems to me that behaviorism was a way for psychology to gain greater acceptance by physical scientists and others outside psychology; for, when dealing only with observables (observed discrete behaviors), a strong claim for scientific precision can be made legitimately. This was all, of course, based on the notion that psychology is the study of behavior. However, this observable only psychology (of behavior) is rather radical, and also limiting, inasmuch as many behaviorists denied the legitimacy or at least the importance of non-observable ideas; e.g., thinking, consciousness, feelings, motives, purposes, images, knowledge, plans, or even the self. Nevertheless, behavior therapy--based upon the "conditioning" work of Watson, Skinner, and Pavlov--per se, without regard to cognition, was until recently quite popular with non-psychodynamically oriented practitioners. Perhaps behavior therapy's popularity was due to often quick results with claims of virtually no symptom substitution.

More recently, and for the most part initially only with research psychologists, there has been a transition away from unilateral behaviorism and toward a new dominant metatheoretical position that emphasizes cognitively mediated processes; i.e., thoughts, affect, behavior, and emotions. Baars (1986) wrote that the decade roughly from 1955 to 1965 saw a quiet revolution in thought take place among the research psychologists with a new (cognitive) point of view; he further stated that cognitive psychology has for all intents and purposes replaced behavioral psychology in a sort of scientific, paradigmatic shift, the sort elucidated by Kuhn (1962).

> Kuhn propounded the notion that scientific knowledge is not merely a cumulative linear progression; instead, after a period of consolidation and quiescence, scientific change takes place when old theories and methods are broken down and replaced. Hence, advances in thought occur via spasmodic paradigmatic change, which are then followed by another period of stability, only to be completely replaced at some later date. (Sigmon, 1990, p. xii)

Perhaps Neisser's (1967) classic work not only named but also whispered about what was to later become a significant theoretical revolution in psychology. Although this change first began with human experimental psychology, it now also encompasses greatly the realm of applied professional psychology as well. In fact, since 1973, interest in cognitive approaches among therapists has increased 600% (Norcross, Prochaska, & Gallagher, 1989).

Exactly how, then, are the cognitive and behavioral approaches brought together in therapy? It is where symbolic cognitive processes are emphasized in order to acquire, eliminate, or even to maintain certain behaviors. Today, it is safe to say that cognitive therapy and behavioral therapy are terms that can almost always be used interchangeably:

> These approaches all share a theoretical perspective that assumes that internal covert processes called thinking or cognition occur, and that cognitive events may mediate behavior change. Furthermore, these approaches all assume that behavioral change does not have to involve elaborate cognitive mechanisms. In some forms of therapy the interventions may have very little to do with cognitive appraisals and evaluations, but may be heavily dependent upon client action and behavior change. (Dobson & Block, 1988, p. 6)

Theoretically, therefore, CBT seeks primarily to change cognitions to alter behaviors, and, to modify cognitions to affect emotions. Dobson (1988) discussed this as follows:

> "cognitive-behavioral" therapies are those that assume that patterns of cognition shape the emotional and behavioral consequences of that cognition. Therapy approaches that do not assume cognitive mediation, or see the concept of cognition as unnecessary--primarily those based on classical and operant conditioning--are not considered here as "cognitive-behavioral." Similarly, therapies that focus exclusively on intrapsychic processes or insight, but that do not explicitly reference psychotherapy outcome by behavioral change are not "cognitive-behavioral." Generally, then, cognitive-behavioral therapies focus on relatively discrete behavioral problems, and these therapies attempt to induce psychotherapeutic gain through changes in the cognitive-behavior complex. (pp. ix-x)

A person's faulty cognitions, illogical or dysfunctional thoughts, and irrational beliefs will lead to self-defeating behaviors and unhappiness. And, in turn, could eventually result in depression, anxiety, phobias, and schizophrenic-like behavior. In essence, I believe that the pathological process of the common psychological disorders centers around certain aberrations in thinking.

To the extent that the cognitive behavioral therapist believes that one's clients have blindspots, hold blurred perceptions, entertain some self-deceptions, and continually engage in certain behaviors that cause anxiety but cannot change on their own, the techniques utilized must, naturally, be able to deal effectively with these sorts of problems. The strategies and procedures used in CBT can be classified into two broad areas, behavioral and cognitive. Moreover, CBT is often done with one or more of four important techniques: changing reinforcement schedules, relaxation training or desensitization, skill training or rehearsal, and cognitive restructuring (replacing irrational thoughts and beliefs with rational ones). The active training/re-arranging of stimulus-response contingencies engaged in by the CBT therapist is the more behavioral aspect, while the more direct cognitive work seeks to help the client change more immediately one's own thinking. Skill training involves teaching the patient certain proficiencies which may be lacking from his/her behavioral repertoire, and then having the patient practice them outside of the therapy session as "homework"; and, having acquired a new cognitive coping skill, this could reduce the patient's anxiety by having gained confidence in one's own self-efficacy. Cognitive restructuring involves getting the patient to see one's self differently, and this can be accomplished, by, for example, therapist questioning, rational disputation, and guided conversation. Having portrayed CBT in this way, it is seen that this is a somewhat integrative system of psychotherapeutic practice.

Perhaps three of the most widely known cognitive behavior therapists are the psychiatrist Aaron T. Beck as well as the psychologists Albert Ellis and Donald Meichenbaum. Beck is well known for his pioneering work in the cognitive treatment of depression and emotional disorders. Beck (1976) wrote that "cognitive techniques are most appropriate for people who have the capacity for introspection and for reflecting about their own thoughts and fantasies" (p. 216). As such, Beck targets "direct, tangible

[cognitive] distortions of reality," "automatic thoughts" and "illogical thinking." Ellis and Meichenbaum, also CBT pioneers, are known for their systems. Ellis (1962) popularized "rational emotive therapy" (RET), and Meichenbaum (1974, 1977) "cognitive behavior modification" (CBM). Ellis's system can be characterized as vigorously disputing or confronting rigid "irrational beliefs" with therapist questioning and "assigning homework" to change cognitions to minimize current self-defeating behavior and future disturbability by becoming more realistic (i.e., desiring rather than demanding) in general outlook (Wolman, 1989). Meichenbaum, meanwhile, who focuses on "internal dialogues," is noted for "skills training" with the "utilization of available information" along with "rehearsal."

In general, CBT is considered an information processing psychology because it suggests, to a great extent, getting people to think differently about themselves and their lives after examining "data" in newly structured ways; and then, they will act differently. (CBT differs from purely cognitive therapies because it may use behavioral means to alter a client's views [Lehman & Salovey, 1990].) However, where CBT differs from most psychodynamic psychotherapies in this regard is that with CBT the therapist takes a very direct, active role. In sharpest contrast to the ordinarily highly directive CBT would be psychoanalytic psychotherapy--exemplified by the psychoanalyst's passive role where occasional interpretations are given.

Another major difference between CBT and psychoanalysis is the latter's emphasis on resolving intrapsychic conflicts (e.g., id vs. superego) and helping the analysand to get in touch with repressed affect. Moreover, in psychoanalysis, therapy involves restarting stalled (psychosexual stage) development. This is done through analysis of real and transference reactions, in addition to interpretations of associations, dreams, and fantasies.

In child analysis, as with adults, the more intact the ego, the greater the chances are for success. Hence, prognosis is better for the less pathological neurotic than the psychotic patient; the latter has difficulty distinguishing primary process (fantasy) from secondary process (reality) thinking. Child psychoanalysis, due to the course of natural development, could be viewed as being more complex than analysis with adults.

> The ego of the young child has the developmental task to master on the one hand orientation in the external world and on the other the chaotic emotional states which exist within himself. It gains its victories and advances whenever such impressions are grasped, put into thoughts or words, and submitted to the secondary process. (A. Freud, 1965, p. 32)

Nevertheless, child analysis is actually quite well suited for phobic youngsters, for it utilizes as a rich source of material night-fears, daydreams, and observations of play. Moreover, mind-created turmoil and infantile complexes would be more open to view than with adults; these things would be less distorted because cover-memories or amnesia are not as strong with the young (A. Freud, 1965).

Not only is psychoanalysis better suited to patients with a more intact ego, but with higher intelligence and more wisdom as well. This is because psychoanalysis relies more on self-discovery. Although enlightenment and self-understanding with less direct intervention/assistance from a therapist may ultimately be more profound for the patient, it is usually a rather slow process; and, being that there is less active involvement on the part of the analyst, the patient may not take action to change one's circumstances until such self-realization occurs--and even then the action taken by the client on one's own, outside the analyst's office, may be insufficient.

In this particular case, Bobby R, a bright lad, suddenly regressed and developed separation anxiety when it came time to attend school; and, as such, would seem to be an ideal case for child analysis. However, as pointed out above, time (which impacts on fiscal resources), degree of client psychopathology, and the level of the patient's intelligence are not as problematic for CBT as they are in psychoanalysis. For these reasons, CBT is often more suitable for school psychology related cases. The sudden onset and the apparent intractible nature of the problem had everyone involved, including Bobby, so upset that getting Bobby back into school as soon as possible seemed to be the best course of action; and, in an effort to accomplish this goal, CBT was chosen. Client service dates from late March until the end of the schoolyear in late June, with follow-up enquiry in September.

Case Background, Interventions and Treatment Literature

Bobby R was brought to my attention by his school principal through a telephone call in late March, while I was working at a different school. This individual--who had begun his administrative career only two weeks earlier after having spent approximately twenty years as a special education classroom teacher--was now confronted with a highly formidable problem. This principal sounded quite agitated, explaining to me that Bobby refused to attend school, the parents were present and quite upset, and they had already tried everything they could (to get Bobby back into school) but to no avail. They were now seeking my assistance in this case.

I would generally meet with parents after gathering certain types of relevant data. However, due to the circumstances and severity of the presenting problem here, I began in a manner more typical of a clinical office case; that is, a parent conference subsequent to a phone call for an appointment. Because I was not engaged in any other pressing activities at the time, I requested the principal ask the parents if they could remain at Bobby's school to meet with me, and they said they would. Thus, I went immediately to Bobby's school, and had my first contact with him and his parents.

Bobby's parents were eager to meet me for they sought help in this matter, and seemed rather appreciative I came promptly to see them. After being introduced to Bobby and his parents by the school principal, and then having some casual conversation with all four other individuals present, I requested to speak privately with the parents. After much coaxing and with great reluctance, Bobby accompanied the principal to an empty adjacent classroom. I listened attentively as the parents explained that except for Bobby's first two days at preschool approximately two years prior, he had easily entered school settings on his own until now.

At this parental conference it was determined that the R's lived close to Bobby's school. He was brought to school everyday by a parent, and he walked home each day after school with neighborhood children except for inclement weather days. His was an all-day Kindergarten through fourth grade school. Bobby was big for his age, and there was no indication of him being bullied either within school or in the neighborhood on his way home from the school. During our meeting, parents conjectured about what

might have caused Bobby's problem. It came to light that two significant changes in routine occurred. First, unlike every other day, Bobby's mother was not in when he walked home from school one recent afternoon exactly one week prior. Mom, knowing she would be delayed, phoned a neighborhood woman, who Bobby knew well, and made arrangements with her to take care of Bobby after school. This neighbor greeted Bobby at his house, said mom would be slightly delayed getting home, and mom would come for him shortly--Bobby reportedly went with her without any difficulty. Additionally, father was home for a two week vacation, both the previous week when mom was delayed as well as the subsequent one when I first met them. Furthermore, Bobby was aware that a three day family trip to Pennsylvania was planned toward the end of father's vacation. Bobby's school refusal began immediately after the incident when mom was late getting home that afternoon. Astonishingly to me, parents had only a mild awareness of the connection between this afternoon incident and Bobby's school refusal. Perhaps it was because they felt by giving him certain assurances, his ultimate response to the late afternoon incident should not have been so strong relative to his attending school. From my point of view, it seemed Bobby had developed an intense fear of family abandonment which he apparently thought would occur during his attendance at school. It was later revealed that mom was accompanied by both dad and younger brother on the afternoon in question! Parents were adamant Bobby must "come to his senses" through verbal exhortations which were futile and often included a tearful "we love you." At this juncture, I told Mr. and Mrs. R that reasoning alone just does not work when emotions are so strong, and fear is a very powerful emotion; but, there are effective ways to deal with this sort of problem which begin with a behavioral approach that later can positively impact upon thinking and emotions. Thus, if we can get Bobby back into class without his fears being realized, he will eventually come to know he really has nothing to be afraid of after all.

Mrs. R initially held strongly to the belief that if the specific cause of Bobby's fear of being at school without a parent present were uncovered, this alone should be able to help him overcome this problem. Mr. R did not seem to believe this, but was also baffled by Bobby's recent school related behavior. I explained to Mr. and Mrs. R that we would try to determine exactly what triggered this reaction from Bobby, although I

hypothesized that it was the late afternoon incident. Furthermore, we might never know for sure; but, in any event, if we do work together to overcome it, we would most likely be successful even if we never know all that relates to the exact precipitating incident--and any other earlier contributing traumatic events. Mrs. R's conception of psychology--as is that, perhaps, of many laypersons--was quite Freudian; i.e., making unconscious material conscious was enough to be curative. I explained to the R's, on a basic theoretical plane which I believed they could understand, that we would not be using a Freudian model of treatment. Rather, we would use a cognitive behavioral one that "does not [necessarily] seek to uncover unconscious trauma of early life," but does place major emphasis on "the child's learning environment" and "the prominence of information processing and mediation in the development, maintenance, and treatment of childhood disorders such as anxiety" (Kendall & Ronan, 1990, p. 227).

In an effort to reassure Mr. and Mrs. R that this situation was not in-surmountable, I explained to them that I have worked successfully with many such cases over the years. This is in keeping with Blagg's (1987/1990) model: "At all stages the therapist needs to come across as confident, helpful, and accommodating but determined that the child should return to full-time school attendance" (p. 144). I explained to Mr. and Mrs. R the difference between school phobia and school refusal: School refusal can be viewed as a form of school-age malingering, whereas with school phobia, the more serious of the two, the child is truly quite fearful of coming to or being in school. And, inasmuch as I did not yet know Bobby, I was not sure what his status was. Regardless, explicated was that the prognosis looked good, based upon my experience as well as the professional literature (Blagg, 1987/1990), because the success rate for school phobic cases is best when the child is young and little time has been lost from school.

I then interviewed Bobby alone. Through our conversation he impressed me as being an obviously very bright boy. He could not, or would not, pinpoint a reason for not wanting to attend school without a parent present. He was somewhat visibly anxious, and told me he was not a baby. (He was accused of acting like a baby by his parents in an effort to get him back into school.) He also expressed apprehension about what might happen if he did not attend school on his own. To put him at ease, I assured him that I

did not at all think he was a baby and he could, initially, probably be allowed to attend school with a parent present; and, when he was ready, he could attend by himself. He said somberly he would never be ready. I asked if he would like to go to his class now if one or both parents would join him, and he said no. He said he was not feeling well, and when asked what was wrong, he responded with "a serious headache."

I sent Bobby back to his parents, and asked them if they would wait briefly for me, to which they agreed. Discussion then took place between myself and the principal with the primary outcome being the principal's approval of my suggestion to allow a parent to sit in Bobby's Kindergarten classroom in an effort to get him back into school as soon as possible. (The agreement with the principal was contingent upon my being "available" should there be any "difficulty.") The principal and I then met with Bobby's parents to discuss a plan to return Bobby to his classroom.

I recommended Bobby be seen very soon by his pediatrician to rule out any medical issues (Blagg, 1987/1990), as his chief reason each morning for not wanting to come to school over the past week was a stomachache. And, if medical illness were ruled out, I proposed the following behavioral plan be rapidly implemented. One parent accompany Bobby to class and remain there with him for one week while he attends school for only half a day. (This would work out nicely, as mom said she "would do whatever it takes to get Bobby back in school"; and, she was not presently working and had no immediate plans to do so. Also, her mother lives close by and could care for Bobby's younger brother if necessary.) "Rewards" (positive reinforcers) were discussed with Bobby's parents, who said among his truly favorite toys were inexpensive miniature cars. So it was decided that for every day Bobby went to school during the first week, he would be presented with a miniature car during dinner, along with lavish parental praise. Then, if that went well, a parent would sit in the hallway near the classroom door for the second week with Bobby still attending for half a day. For the second week, toy cars would be given to Bobby at dinnertime after the first day (Monday) and then every other day (Wednesday and Friday). Being that I thought the cars would have much less impact (reinforcing value) by week three, it was recommended that Bobby and his parents mutually agree upon a different weekend toy or activity as a "reward for the completion of a (prior) successful week of school

attendance" for the next few weeks; this change would commence at the end of week two. The third week would entail Bobby's classroom presence for a half day, with a parent staying by the front door of the school building. Bobby would be allowed to "check" from time to time to ensure the presence of this parent. The fourth week would have Bobby stay in school by himself for a half day, with mom at home; but Bobby would be allowed to call her from the phone in the school office if he had a need to do so. If all went well as per this plan, Bobby would be attending all day by the fifth week but would still have access to the telephone in the school office. Moreover, I would monitor Bobby's daily behavior, and work closely with mom and the Kindergarten teacher. Finally, after week five objective was achieved, I would work once a week with Bobby on a one-to-one basis and more if needed until the schoolyear ended. (I did not want to see Bobby alone during the first five weeks of the plan because I believed he would be too anxious if mom were not present, and his anxiety level was already so high regarding school--and, I obviously was associated greatly with school.) Mr. and Mrs. R along with the school principal agreed completely to the plan as proposed. Mr. and Mrs. R told me they wanted to begin as soon as possible, and said they would participate fully.

This plan, in behavioral terms, is a positive effort via contingency management to have Bobby attend school on a regular basis by fading out simultaneously two reinforcers (Whaley & Malott, 1971)--mother in school and toys or desired activities outside school. The rewards were contingent upon behavioral objectives being achieved. More specifically, two positive reinforcement schedules are used, at first continuously, and then changing them to decreasing fixed intervals (Whaley & Malott, 1971). Ultimately, if successful, the school non-attending behavior will be extinguished (Ayllon, Smith, & Rogers, 1970; Vaal, 1973). From a purely cognitive aspect, if Bobby attends school and finds (by processing information differently now) that his fear of abandonment or some other fear does not materialize, he can give up his irrational thoughts in this regard. Thus, as his self-efficacy increases, he will gain confidence as he comes to know that attending school need not be feared, and through this new cognitive mediation, his emotional adjustment will improve as well (Dobson & Block, 1988).

With a proposed treatment plan in place, what remained to be done was to prepare the teacher (Blagg, 1987/1990), await the results of the medical exam, review Bobby's permanent cumulative school record, discuss other relevant family background features with the parents, make a definitive differential diagnosis, and implement the plan--unless new data suggests otherwise.

It was learned that there was no medical basis for Ricky's recent stomach pains or headaches. I reviewed Bobby's school folder, and found nothing contributory to his recent problematic school behavior except for one possible highly significant item: Mr. R was not Bobby's natural father and he had legally adopted Bobby last October, according to a copy of a legal document therein; this was an issue which I discussed with Mrs. R at our subsequent meeting. Mrs. R told me she was sure Bobby was totally unaware Mr. R was not his natural father, as Mr. R and Mrs. R have resided together continuously for over four years; and, she has had no contact with Bobby's natural father since he moved to California approximately five years ago. Bobby was born 6-1/2 years ago. Bobby's younger half-brother, M, was born three years after Bobby. For both boys, birth was normal with no complications, development in all areas was average or perhaps slightly early, and there have been no hospitalizations or noteworthy illness or injury. Parents have had good health over the years. Mrs. R is 30, and was born and grew up in the area where Bobby attends school. Mr. R, 31, is a truck driver for a local company; and, although he also was born in this area, he grew up in Pennsylvania where his parents still reside. Mr. R returned to this area for employment, and met the now Mrs. R at that time.

A preparation conference with Bobby's teacher was held where it was learned she was surprised over Bobby's sudden reversal; there were no prior problems. I advised her of the plan to re-integrate Bobby back into her class, and asked for her input regarding it. She really had nothing to add, but only wanted to know what she could do to help. My recommendations to her were that if initial or later occasional tantrums occurred she should try to ignore them; but, if they were too severe, she should ask mom to escort Bobby to the empty classroom by the school office to allow him to calm down. Also, teacher should try to make Bobby feel comfortable but otherwise treat him like the other students. Moreover, if other pupils ask about Bobby's behavior and his mother's presence, she was to tell them that

Bobby has been upset lately and his mom is a temporary visitor who is there to help him. The plan was to be implemented the next Monday, in early April.

Assessment of Bobby R yields a DSM-III-R (American Psychiatric Association, 1987) differential diagnosis of:

AXIS I: "Separation anxiety disorder" (309.21), as evidenced by:

1. unrealistic and persistent worry . . . major attachment figures. . . will leave and not return,
2. persistent reluctance or refusal to go to school in order to stay with major attachment figures, and
3. complaints of physical symptoms, e.g., headaches, stomachaches . . . on many school days.

AXIS II: "No diagnosis on Axis II" (V71.09).

AXIS III: No diagnosis.

The DSM-III-R does not contain a specific "school phobia" nosological category.

Blagg (1987/1990), in an extensive review of the school phobia literature, found that early treatment work was psychoanalytically based; and, most psychodynamically oriented therapists, as do most all behavior therapists, favor an early return to school. Moreover, recent work in this area is predominantly geared toward behavioral techniques (Blagg, 1987/1990). Although both psychodynamic and behavioral treatment for school phobia can be successful, the latter usually yields a much quicker return to school (Ayllon, Smith, & Rogers, 1970; Blagg, 1977, 1987/1990; Vaal, 1973). Indeed, behavioral treatment combined with cognitive aspects appears more efficacious than behavioral methods alone as the former is more encompassing (Blagg, 1977, 1987/1990; Hughes, 1988; McReynolds, Morris, & Kratochwill, 1989; Morris & Kratochwill, 1983), with Morris and his associates favoring the addition of self-control, among other, CBT techniques for childhood fears.

Blagg (1987/1990) recommends a diagnostic/treatment approach--based upon Miller, Barrett, and Hampe's (1974) formulation--which is primarily behavioral but also involves subtle school, family, and personal issues; it is below:

a. establishing good relationships with the child, the family and the school;
b. clarifying the real or imagined events that have caused the anxieties;
c. desensitising the child and if necessary the parents and teachers through a variety of techniques including discussion, humour, role rehearsal and emotive imagery; and
d. confronting the feared situations through forced school attendance. In addition, home and school related operant factors are dealt with through advice on contingency management. In essence, the clarification element encompasses systematic problem-solving procedures whilst the other elements involve the application of a comprehensive range of behavioural techniques tailored to the needs of each particular case. (pp. 117-118)

As with most complex situations in life, our plans do not always unfold exactly as envisioned. The five week behavioral intervention part of the plan was highly successful, except that it became a seven week plan. We kept to the original format as much as possible but there were some days which contained significant setbacks. For instance, days one and two of the first week were fine; but on the third day, Bobby refused to go to school. Father--who was able to leave work--assisted mother in taking Bobby to school that morning instead of mother alone, as was the situation the two earlier days. Bobby got out of the family stationwagon, but would not enter the school building; and, he was visibly tense and shaking. Mr. R, a huge man, was obviously quite frustrated; yet, in an effort to get Bobby into school, he was gentle and soft spoken. Nevertheless, Bobby would not enter the building. I noticed that younger brother M was also present, and knew M stayed with grandmother days one and two. Mom said she was going to come to school with younger brother this third day and Bobby knew this. I did not know what the connection was between Bobby coming to school and the younger brother's presence--perhaps sibling rivalry or embarrassment. In any event, because Bobby was so anxious this day, I told the parents to take him home (even though he would not enter school) and try again tomorrow. However, I suggested that M not be taken to school during week one when a parent was to sit in the classroom. The next day was without incident. There were a few other setbacks, although none so intense as day three. Mom was able to take along M without any problem by the time she was positioned at the school building door (original week three). The two days when she brought along M and sat outside the classroom door (original week two) there were problems. Thus, there was a

connection between Bobby attending and the brother's presence with mom near Bobby's classroom; the exact reason for this was really never determined, but Bobby definitely regressed in this situation. By the middle of May, Bobby's school attending behavior was the same as before the problem first began in March: Perfect attendance without a parent near the school.

During the second half of May, I began to meet with Bobby at least twice weekly. Even though the original plan had called for me to see him once a week and as needed, with the schoolyear's end rapidly approaching, I deemed it necessary to see him more often. I now not only wanted to work with Bobby more intensively than originally planned to ensure continued success for the balance of the schoolyear, but to provide the additional sessions in an effort to help him to be on track from day one for the following schoolyear.

With the behavioral work (greatly involving positive reinforcement) now having been completed successfully, I implemented immediately a treatment approach which was purely cognitive in nature. According to Morris and Kratochwill (1983), "Two of the most promising methods of fear reduction involve the use of positive reinforcement and self-control" (p. 80); moreover, "self-control" is a "cognitive behavior therapy" that "actually encompasses numerous intervention methods" which "focus on helping individuals develop specific thinking skills and apply these skills whenever they are confronted with a particular feared stimulus, event, or object" (p. 78). My cognitive approach focused primarily on self-control through cognitive restructuring and "comforting self-talk" (Morris & Kratochwill, 1983; Peterson & Shigetomi, 1981) modalities. Similarly, for impulsive school behavior, recommended are getting "children to talk to themselves" (Meichenbaum & Goodman, 1971), "self-control therapy" (Kendall & Braswell, 1982), and "cognitive self-instruction" (Manning, 1990), while Meichenbaum (1977) has been using "coping self-statements" in general with clinical success.

Bobby had begun to believe that his parents would still be there for him after school; also, through our sessions, Bobby had learned to use as a coping technique comforting self-talk to deal with any anxiety that might occur regarding this during school hours. (No other serious phobia was brought to light. And, although adoption was deliberately never discussed by me with Bobby, I suspect that with Bobby being so bright a young child

he might have overheard some talk of this at home and developed some distorted thoughts about it; this could have impacted upon Bobby's recent school problem. The issue of adoption is a serious one that will in all probability emerge in the future and require careful handling.) Bobby had grown more and more comfortable during his last three months in Kindergarten; and, as a result, the significant adults in his life became less tense.

Conclusion

It was obvious through the way Bobby generally conducted himself in school as well as what he said that he was growing rapidly in self-efficacy. Enhancing self-efficacy "involves helping the client distinguish between the past and present once progress has been made. The past may serve as an anchor against which to measure clients' progress" (Lehman & Salovey, 1990, p. 251). Near the very end of the schoolyear, when I reminded Bobby of our first meeting where he told me he would never be ready to attend school without a parent present, he laughed joyously and said, "I'm not a baby anymore." At the close of the academic year, I could not know if Bobby would start first grade without any remnants of the problem that was so debilitating to him; but, I was absolutely sure, if the problem re-emerged, it would not be as severe.

By the end of the academic year, Bobby could again walk home from school without a parent. At that time, he verbalized to me he was still slightly anxious when at school away from his parents. Yet, during our late June conversations and classroom observations, Bobby appeared relaxed and participated fully plus appropriately with peers and teacher, who also reported the same.

Because of Bobby's apparent residual anxiety and his parents' fear of possible regression by Bobby over the summer, Mrs. R asked me in late June if I thought taking Bobby for therapy over the summer would be helpful. I told her I thought it would be beneficial under the circumstances, and she said they would therefore be seeing someone in a nearby municipality who was recommended by Bobby's pediatrician. A September follow-up call revealed that Bobby began first grade without incident, and he no longer seems anxious over separation from parents.

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